

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15565

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15567

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>DOR.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENABRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOOLFORD</u>	
c. LENGTH OF STAY IN 1b <u>14 Mo.</u>		d. STREET ADDRESS <u>09-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GLASGOW NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE E. ADAMS</u>		4. DATE OF DEATH Month Day Year <u>11 12 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 21 1880</u>
9. AGE (In years lost birthday) yrs. <u>86</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Dwight C. ADAMS</u>		Address <u>WOOLFORD Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		22. DATE SIGNED <u>11/12/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/15/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Laurel Sussex Del</u>	
24. FUNERAL DIRECTOR <u>Mr. D. S. Harrison</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15566

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15566

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>			
c. LENGTH OF STAY IN 1b <u>3 1/2 yrs</u>				d. STREET ADDRESS <u>Main</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)							
3. NAME OF DECEASED (Type or print) <u>William August Asmussen</u>				4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/17/1892</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former - Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Asmus Asmussen</u>			
14. MOTHER'S MAIDEN NAME <u>Maria Jensen</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. J. M. Richardson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency, Biliary Cirrhosis</u> DUE TO (b) <u>Chronic Congestive Cardiac Failure &amp; ?</u> OUE TO (c) <u>Previous Alcoholism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5wks</u> <u>5yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old Burnt Out Chronic Rheumatoid Arthritis Bleeding Diverticuli</u>							
19. WAS AUTOPSY PERFORMED? <u>NO</u>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>6/23</u> , 19 <u>64</u> , to <u>11/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> , 19 <u>66</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold B. Plummer</u>				22b. DATE SIGNED <u>11-17-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer M.D.</u>				22d. ADDRESS <u>Preston Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE THEREOF <u>11/18/66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Cambridge</u>				23d. LOCATION (City, town or county) (State) <u>Cambridge, Md</u>			
24. FUNERAL DIRECTOR <u>Charles J. Mullough, East New Market</u>				25a. REC'D BY REGISTRAR <u>Charles J. Mullough</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles J. Mullough</u>				OATE <u>NOV 18 1966</u>			

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FOR STATE  
HEALTH DEPT

Items 18-21 Film 382 11-17-66											
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15569											
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN lb <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookview</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland</b>						d. STREET ADDRESS <b>---</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helena L. Bailey</b>			First Middle Last			4. DATE OF DEATH <b>November 8 19 66</b>			Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/6/45</b>		9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pickle factory labor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Frederick Taylor</b>						14. MOTHER'S MAIDEN NAME <b>Cartwright</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records Cambridge Hospital</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending autopsy Broncho Pneumonia</b> <b>8915</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Carbon Monoxide poisoning</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found in auto with motor running</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11-6</b> 19 <b>66</b> p.m.				20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Brookview Dorch Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Mace Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>11/8/66</b>			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Nov 11 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Milton, Delaware</b>		
24. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>						25a. REC'D BY REGISTRAR <b>NOV 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>						<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Md</u> b. COUNTY <u>Dor</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> <u>09.1</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lillian Dewey Busta</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>3</u> Year <u>1966</u>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1/14/1896</u>		<b>9. AGE (In years last birthday)</b> <u>70</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>House work</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Maryland</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>John Spear</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Harper</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>John Busta, Hurlock, Md</u> Address _____					
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive C.V.D.</u> DUE TO (c) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 days</u> <u>hrs</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town)</b> _____		<b>(County)</b> _____ <b>(State)</b> _____	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10-31</u>, 19<u>66</u>, to <u>11-3</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>11-3</u>, 19<u>66</u>, and that death occurred at <u>2:00 P.M.</u>, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>W. Baumann</u>						<b>22b. DATE SIGNED</b> <u>11-4-66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Wilbur N. Baumann, M.D.</u>			
<b>22d. ADDRESS</b> <u>603 Church St. Cambridge, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>11/5/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington</u>		<b>23d. LOCATION (City, town or county)</b> <u>Hurlock</u>		<b>(State)</b> <u>Md</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Edith S. Mellowby, East New Market</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>NOV 9</u> 19 <u>66</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>			

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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div> <div>13. STATE OF MARYLAND</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>15571</div> </div>																
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b> c. LENGTH OF STAY IN life <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Jones Village</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b> d. STREET ADDRESS <b>Jones Village</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>Abraham Lincoln Cephas</b>			<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>12</b> Year <b>1966</b>		<b>5. SEX</b> <b>Male</b>			<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 12, 1924</b>		<b>9. AGE</b> (In years last birthday) <b>42</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Caroline Poultry</b>					<b>11. BIRTHPLACE</b> (State or foreign country) <b>Hurlock, Maryland</b>					<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John H. Cephas</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary S. Ross</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>218-16-9930</b>			<b>17. INFORMANT</b> <b>Mary L. Johnson, Hurlock, Maryland</b>			<b>Address</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fractured skull</b> <b>8124</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Instant</b>				
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased was walking on the road and was struck by an automobile.</b>											
<b>20c. TIME OF INJURY</b> Hour <b>5:40 P.M.</b> Month <b>November</b> Day <b>12</b> Year <b>1966</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Skeet Club Road</b>			<b>20f. (City or town)</b> <b>Hurlock</b>		<b>(County)</b> <b>Dor.</b>		<b>(State)</b> <b>Maryland</b>				
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
<b>ACTUAL SIGNATURE</b> <i>Lawrence Maryanov</i>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>					<b>DATE SIGNED</b> <b>11/15/66</b>						
<b>EXAMINER'S NAME</b> (Type) <b>Lawrence Maryanov, M.D.</b>					<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>					<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						
<b>Address</b> (Street, city, town, or county) <b>610 Race St., Cambridge, Md.</b>																
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>22b. DATE THEREOF</b> <b>Nov. 15, 1966</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>East New Market Cemetery</b>			<b>22d. LOCATION</b> (City, town, or county) (State) <b>East New Market, Maryland</b>								
<b>23. FUNERAL DIRECTOR</b> <i>J. J. Frampton Jr.</i>					<b>ADDRESS</b> <b>J. J. Frampton and Son, Federalsburg, Maryland</b>					<b>24a. REC'D BY REGISTRAR</b> <b>NOV 17 1966</b>					<b>24b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE  
HEALTH DEPT.

15570

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15572

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 mos. 9 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - PRINCESS ANN</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Millard</u> First <u>Dashiell</u> Middle Last		4. DATE OF DEATH <u>Nov.</u> Month <u>19</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-97</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Water</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Dashiell</u>		14. MOTHER'S MAIDEN NAME <u>Lula Dashiell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>217-12-4501</u>	
17. INFORMANT <u>Med. Records</u> Address <u>Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> 9037 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture neck R. femur</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>3 mo.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Fell to floor in hospital</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p.m. <u>8/15/1966</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) (County) (State) <u>Cambridge</u> <u>W. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		22. DATE SIGNED <u>11/15/66</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov 21, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oriole</u>	23d. LOCATION (City or Town) (County) (State) <u>Oriole Somerset Md.</u>
24. FUNERAL DIRECTOR <u>James Herman Finner</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 22 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY		Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE		Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Vienna, Maryland R.D.		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Vienna, Maryland Rural		091	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		R.F.D. # 1-Box 183		d. STREET ADDRESS		R.F.D. # 1-Box 183		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Phillip		Middle Lee Goldsborough		Last Dennard, Sr.		4. DATE OF DEATH Month November		Day 17 Year 1966	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1900		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Foreman		10b. KIND OF BUSINESS OR INDUSTRY Royal Pkg. Co., Vienna		11. BIRTHPLACE (County & State, or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Wesley Dennard		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Davis		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-03-1657		17. INFORMANT Mrs. Hattie Mae Dennard, Vienna, Md. R.D.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Generalized osteoblastic metastases Carcinoma of prostate		INTERVAL BETWEEN ONSET AND DEATH 6 months 1 yr.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/4/65 to 11/16/66, that (I) (we) last saw the deceased alive on 10/21/66, and that death occurred at 3:30 PM, from the causes and on the date stated above.		22a. SIGNATURE Lawrence Maryanov		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/19/66			
22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov		22d. ADDRESS 610 Race St Cambridge, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 21, 1966		23c. NAME OF CEMETERY OR CREMATORY Vienna Methodist Church		23d. LOCATION (City, town or county) (State) Vienna, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Framptom and Son		ADDRESS Federalsburg, Md.		25a. REC'D BY REGISTRAR DATE NOV 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

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Vienna, Maryland, 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15572 CERTIFICATE OF DEATH 155725											
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Church Creek</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Church Creek Md.</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Church Creek</b> d. STREET ADDRESS <b>Church Creek Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Edna Carrie Dunnock</b>						4. DATE OF DEATH <b>November 22 1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 Jan. 1892</b>		9. AGE (in years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Church Creek Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>A. Bowdle Robinson</b>						14. MOTHER'S MAIDEN NAME <b>Annie Willis</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-36-6048</b>		17. INFORMANT <b>B Donald Richardson</b>				Address <b>Cambridge Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/9/66</b> , 19, to <b>11/22/66</b> , 19, that (I) (we) last saw the deceased alive on <b>11/16/66</b> , 19, and that death occurred at <b>9:14</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Lawrence Maryanov</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/23/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>						22d. ADDRESS <b>610 Race St. Cambridge, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>24 Nov. '66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cambridge Md.</b>			
24. FUNERAL DIRECTOR <b>Robert L. Jones</b>						ADDRESS <b>Cambridge Md. 21613</b>		24a. REC'D BY REGISTRAR <b>NOV 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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Handwritten notes and signatures, including a large signature at the bottom.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15573

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Tal.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u> - Box 332	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp</u>		d. STREET ADDRESS <u>20-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>B.</u> Last <u>Edie</u>		4. DATE OF DEATH Month <u>11</u> Day <u>-24</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-26-82</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Mandens</u>	
14. MOTHER'S MAIDEN NAME <u>Emma Sommerus</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-26-7712</u>		17. INFORMANT <u>E. S. H. Records Cambridge Md</u> Address <u>Cambridge Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>pulmonary pneumonia</u> DUE TO (c) <u>general debility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>a week</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>62</u> to <u>11-24</u> , 19 <u>66</u> that (I) (we) lost the deceased on <u>11-24</u> , 19 <u>66</u> and that death occurred at <u>3:40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Rene E. Smith</u>		22b. DATE SIGNED <u>11-24-66</u>	22c. PHYSICIAN'S NAME (Type) <u>M.D.</u>
22d. ADDRESS		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/28/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u>	23d. LOCATION (City or Town) (County) (State) <u>Oxford, Md.</u>
24. FUNERAL DIRECTOR <u>Maurice E. Keenan - Son</u> ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 28 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (RURAL)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYDEL, Maryland</u>	
c. LENGTH OF STAY IN TB <u>1 year 4 mos</u>		d. STREET ADDRESS <u>05-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George William ELIAS</u>		4. DATE OF DEATH Month Day Year <u>11 6 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>00-08-93</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Not Known - John W. Elias</u>		14. MOTHER'S MAIDEN NAME <u>— Lettie Murray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Eastern Shore State Hospital (Med. Records)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage with</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Myocardial infarction</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <u>8/2, 1965</u> , to <u>11/6, 1966</u> , that (he) (we) last saw the deceased alive on <u>11/6, 1966</u> , and that death occurred at <u>7:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. Rieckert</u>		22b. DATE SIGNED <u>11-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. Rieckert</u>		22d. ADDRESS <u>E-New Market</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EMMANUEL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>R.F.V.H. 3 Chester Town MD</u>
24. FUNERAL DIRECTOR <u>Sennett Webb</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE NOV 10 1966	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15575

CERTIFICATE OF DEATH

15578

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>			c. LENGTH OF STAY IN IB <b>7 WEEKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MICHAELS</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUSSELL CLIFFORD FAIRBANKS</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 3 19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/04</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CLAY R. FAIRBANKS</b>				14. MOTHER'S MAIDEN NAME <b>ELVA SEYMOUR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>704-18-1410</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 11, 1966</b> , to <b>NOV. 3, 19 66</b> that (I) (we) last saw the deceased alive on <b>November 3, 1966</b> , and that death occurred at <b>3:20 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Carlos F. Barroso</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/3/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARLOS F. BARROSO MD</b>				22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-14-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med School</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Barker M. Forest</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15576

CERTIFICATE OF DEATH

15579

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, (RURAL)</b>		c. LENGTH OF STAY IN 1b <b>4 MONTHS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FIELDS</b> Last <b>FIELDS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>06-01-91</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY FIELDS</b>		14. MOTHER'S MAIDEN NAME <b>MOLLIE FIELDS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>216-18-2200</b>	
17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Felipe Dominguez</b>		22b. DATE SIGNED <b>11-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>FELIPE DOMINGUEZ M.D.</b>		22d. ADDRESS <b>EASTERN SHORE STATE HOSPITAL</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/28/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia</b>		23d. LOCATION (City or Town) (County) (State) <b>Dames Quarter, Maryland</b>	
24. FUNERAL DIRECTOR <b>William H. Jones</b>		25a. REC'D BY REGISTRAR <b>NOV 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15577

CERTIFICATE OF DEATH

15580

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wic. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mandella Bay 5</u>		d. STREET ADDRESS <u>RFD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Otto JAMES Gattis</u>		4. DATE OF DEATH <u>11-23-66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-14</u>
9. AGE (In years last birthday) <u>52</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmworker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wane Gattis</u>		14. MOTHER'S MAIDEN NAME <u>Desields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-6227</u>	
17. INFORMANT <u>Records E. S. S. Hosp - Cambridge</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branch pneumonia and</u> DUE TO <u>pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-19, 1966</u> to <u>11-23, 1966</u> that (I) (we) lost saw the deceased alive on <u>11-23, 1966</u> and that death occurred at <u>11:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. Keckel</u>		22b. DATE SIGNED <u>11-23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. Keckel</u>		22d. ADDRESS <u>E. - New Market, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 27, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Head of Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Near Quantico, Maryland</u>
24. FUNERAL DIRECTOR <u>Hampton Funeral Home Frederickburg</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 28 1966</u>	

0326

252

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15578

15581

<b>1. PLACE OF DEATH</b> a. COUNTY <b>DORCHESTER</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE (RURAL)</b>			c. LENGTH OF STAY IN 1b <b>21 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BISHOP, MARYLAND</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ORLANDA</b> Middle <b>HALL</b> Last				<b>4. DATE OF DEATH</b> Month <b>NOVEMBER</b> Day <b>1</b> Year <b>1966</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>01-20-91</b>		<b>9. AGE</b> (In years last birthday) <b>75</b> yrs.	<b>10. IF UNDER 1 YEAR</b> Months Days	<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>iron farm</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>MIRAN HALL</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH HALL</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b> <b>222-10-1929</b>		<b>17. INFORMANT</b> Address <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>GENERAL DEBILITATION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRAIN SYNDROME</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>NA</b>				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> attended the deceased from <b>Oct 11, 1966</b> , to <b>Nov 1, 1966</b> , that <b>he</b> (we) last saw the deceased alive on <b>Nov 1, 1966</b> , and that death occurred at <b>4:53 PM</b> , from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>John B. Webster, M.D.</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>1 Nov 1966</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>JOHN B. WEBSTER M.D.</b>				<b>22d. ADDRESS</b> <b>EASTERN SHORE STATE HOSPITAL</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov 15, 1966</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lewis Cem.</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Whaleysville Worcester Md.</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Richard T. Watson, Edgemoor</b>				<b>25a. REC'D BY REGISTRAR</b> DATE <b>NOV 7 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR CHESTER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15579

CERTIFICATE OF DEATH

15582

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge - Rural</u>		c. LENGTH OF STAY in 1b <u>2 mos. 11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels - Rural 20-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Box 123</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernice</u> Middle <u>HARRISON</u> Last <u>HARRISON</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>F.m.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-98</u>	9. AGE (In years last birthday) <u>68 yrs.</u>	10. IF UNDER 1 YEAR Months <u>11</u> Days <u>12</u>		11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Caulk</u>				14. MOTHER'S MAIDEN NAME <u>Ellie - Caulk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-36-5931</u>		17. INFORMANT <u>Eastern Shore State Hospital - Med. Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Congestive Heart Failure</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>? 12 hrs</u> <u>? 2 1/2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>9/1/66</u> , 19 <u>66</u> , to <u>11-12</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>11-12</u> , 19 <u>66</u> , and that death occurred at <u>11:15</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Edward Lewis, Jr.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR., MD</u>				22d. ADDRESS <u>EASTERN SHORE STATE HOSPITAL -</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Nov 15 - 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wood Lawn Cwtry</u>		23d. LOCATION (City or Town) (County) (State) <u>Easton, Md</u>	
24. FUNERAL DIRECTOR <u>Stanley Harrison, St. Michael</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	



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RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15580					15583				
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>511 Cedar Street</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>511 Cedar Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>May Henry</b>			4. DATE OF DEATH <b>Nov. 12 19 66</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>May 15, 1897</b> 9. AGE (in years last birthday) <b>69</b> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>John Henry Stanley</b>			14. MOTHER'S MAIDEN NAME <b>Julia Mary</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Elsie Roles</b> Address <b>1918 Hope St. Balti. Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1, 1966</b> to <b>Nov. 12, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov. 12, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>J. Edwin Fassett, M.D.</b>					22b. DATE SIGNED <b>11-14-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>					22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>		
24. FUNERAL DIRECTOR <b>J. Edwin C. Fassett</b>					ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

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John Henry Taylor  
Kane Hotel 1718 1st St. S.W.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15581					15584				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Dorchester</b> MARYLAND					a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Trappe</b>				
c. LENGTH OF STAY IN 1b <b>Few Hrs.</b>					d. STREET ADDRESS <b>2902</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			
First Middle Last <b>Edward Alexander Hughes</b>			Month Day Year <b>Nov. 8, 1966</b>			Male			
6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<b>Negro</b>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>Apr. 20, 1910</b>		<b>56</b> yrs.		<b>Minister</b>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<b>Belmar, N. J.</b>		<b>USA</b>		<b>Alfred Hughes</b>		<b>Willie Neal</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<b>No</b>		<b>214-12-6873</b>		<b>Mary Hughes, Trappe, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 hours</b> (c) <b>4 hours</b>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>November 8, 1966</b> , to <b>November 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>November 8, 1966</b> , and that death occurred at <b>P</b> M, from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
<b>Je Edwin Fassett, M.D.</b>					<b>11-10-66</b>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
<b>Je Edwin Fassett, M.D.</b>					<b>727 Pine Street Cambridge, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<b>Burial</b>		<b>11/13/1966</b>		<b>East New Market</b>		<b>East New Market, Md.</b>			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR				
<b>Frederick C. Davis</b>					<b>NOV 14 1966</b>				
25b. REGISTRAR'S SIGNATURE									
<b>Charles Judge</b>									

15284

15284

THE  
STATE OF  
NEW YORK  
IN SENATE  
January 10, 1907.  
REPORT  
OF THE  
COMMISSIONER OF  
THE LAND OFFICE  
IN RESPONSE TO  
A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 10, 1906.  
ALBANY:  
J. B. LIPPINCOTT & CO.,  
PRINTERS.  
1907.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

15582

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15585

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Salem--U.S. Rt. 50</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First RAYMOND Middle HURLEY Last</b>		4. DATE OF DEATH Month <b>Nov. 15,</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1883</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dirt</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Hurley</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Catherine ??</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs. William Ewell, Salem, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> <b>5711</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Entero-colitis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr. M.D.</b>		22. DATE SIGNED <b>11/17/66</b> <b>Cambridge, Md.</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 18 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1966</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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*John M. Smith*

12525



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15583

15586

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>			c. LENGTH OF STAY in 1b <u>2 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAMES QUARTERS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSP.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARSHALL</u> Middle <u>m.</u> Last <u>HYLAND</u>				4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1966</u>				
5. SEX <u>m</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-7-99</u>		
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>69</u> Hours <u>69</u> Min. <u>69</u>		IF UNDER 24 HRS. Months <u>69</u> Days <u>69</u> Hours <u>69</u> Min. <u>69</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer + Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Somerset, Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam Hyland</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>220-03-3782</u>		17. INFORMANT <u>EASTERN SHORE STATE HOSP.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-9</u> , 19 <u>66</u> to <u>11-19</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-19-66</u> , 19 <u>66</u> , and that death occurred at <u>2:35</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>Peter W. Rieckert</u>				22b. DATE SIGNED <u>11-20-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		
22d. ADDRESS <u>E-New Market Rd.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dames Quarters</u>		23d. LOCATION (City or Town) (County) (State) <u>Dames Quarters</u>		
24. FUNERAL DIRECTOR <u>Lewis Wilson</u>				25. REC'D BY REGISTRAR <u>Nov 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15584					15587				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Dorchester</b> MARYLAND					a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>2 wks.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>East New Market</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital, Inc.</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frederick A. Jackson</b>			4. DATE OF DEATH <b>November 26 1966</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 8, 1878</b>		9. AGE (In years last birthday) <b>88 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Jackson</b>					14. MOTHER'S MAIDEN NAME <b>Mary Louise Cornish</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-20-6828</b>		17. INFORMANT <b>Minnie Jackson E. New Market, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic CD</b> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>11 Nov</b> , 19 <b>66</b> , to <b>26 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>26 Nov</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>J. Edwin Fassett</b>					22b. DATE SIGNED		22c. ADDRESS <b>727 Pine Street Cambridge, Md.</b>		
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>					22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/30/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>		23d. LOCATION (City, town or county) (State) <b>East New Market, Md.</b>		
24. FUNERAL DIRECTOR <b>Frederick C. J. Fair</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

15583

15583

Patented by

Best and Latest

John W. ... Inc.

NO. 1,113,113

Patented May 1, 1914

John W. ...

John W. ...

John W. ...

John W. ...

John W. ...

John W. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15585

15588

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>Taylors Island</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital, Inc.</b>				d. STREET ADDRESS <b>171</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Keene, Jr.</b> Last <b>Nov.</b>				4. DATE OF DEATH Month <b>11</b> Day <b>19</b> Year <b>66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 9, 1901</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>65</b> Days <b>11</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>65</b> Days <b>11</b> Hours <b>19</b> Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John Keene, Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Martha Keene</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>213-07-8926</b>				17. INFORMANT <b>Lillian Keene Taylors Island</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 4221 DUE TO <b>Coronary heart of atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis CVD</b> (c) <b>Arterio Sclerosis CVD</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1966</b> to <b>Nov 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 11</b> 19 <b>66</b> , and that death occurred at <b>2:00</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James C. Thompson</b>				22b. DATE SIGNED <b>Nov 11, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. U. Thompson, M.D.</b>				22d. ADDRESS <b>602 Locust Street Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Taylors Island</b>	
23d. LOCATION (City, town or county) (State) <b>Dorchester Co., Md.</b>				23e. LOCATION (City, town or county) (State) <b>Dorchester Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Frederick C. Blair</b>				24a. ADDRESS <b>Cambridge, Md.</b>			
25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

15282

15282

Wm. C. Thompson  
1875

Wm. C. Thompson

Wm. C. Thompson



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE (RURAL)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARYDEL</b>	
c. LENGTH OF STAY IN 1b <b>36 DAYS</b>		d. STREET ADDRESS <b>None</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>KELSON</b> Last		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-14-1883</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH KELSON</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN Wilmina Hackett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>- No</b>		16. SOCIAL SECURITY NO. <b>- None</b>	
17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 16</b> , 19 <b>66</b> , to <b>Nov 28</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Felipe M. Dominguez</b>		22b. DATE SIGNED <b>11/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>FELIPE M. DOMINGUEZ, M.D.</b>		22d. ADDRESS <b>F.S.S.H.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-2-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>	23d. LOCATION (City or Town) (County) (State) <b>Marydel, Md.</b>
24. FUNERAL DIRECTOR <b>John Boula's Greenabow and</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

12538

12538

FRONTIER OF DEATH

STATE OF TEXAS

25 DAYS

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15587

## CERTIFICATE OF DEATH

15590

<b>1. PLACE OF DEATH</b> a. COUNTY <b>DORCHESTER</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b> c. LENGTH OF STAY IN 1b <b>2 YR. 9 MO.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>WICOMICO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> d. STREET ADDRESS <b>317 CHESTNUT WAY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>SARAH JANE LEMON</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>NOVEMBER 17 19 66</b>				
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>12/26/69</b>	<b>9. AGE</b> (In years lost birthday) <b>96</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>10 21</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>--</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Mo. Wicomico County</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>			<b>13. FATHER'S NAME</b> <b>CHARLES Sturgis</b>				
<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY - Parsons</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				
<b>16. SOCIAL SECURITY NO.</b> <b>-</b>			<b>17. INFORMANT</b> <b>Mr. George Lemon, 317 Chestnut Way (Son)</b> <b>HOSPITAL RECORDS Salisbury, Maryland</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basal cell carcinoma on face</b> 1913 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 years</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II at item 18.) <b>N/A</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>2/15</b> , 19 <b>65</b> , to <b>11/17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> , 19 <b>66</b> , and that death occurred at <b>12:30 PM</b> , from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Carlos F. Barroso</b>				<b>22b. DATE SIGNED</b> <b>11/17/66</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>CARLOS F. BARROSO, M.D.</b>				<b>22d. ADDRESS</b> <b>E.S.S.H., CAMBRIDGE, MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov. 19, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>			
<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Salisbury, Maryland</b>		<b>24. FUNERAL DIRECTOR</b> <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>					
<b>25a. REC'D BY REGISTRAR</b> DATE <b>NOV 23 1966</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

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DEPARTMENT OF DEATH

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ALL INFORMATION MAY

ALL INFORMATION MAY

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ALL INFORMATION MAY BE OBTAINED BY THE PUBLIC AT THE NATIONAL ARCHIVES AT COLLEGE PARK, MARYLAND. FOR MORE INFORMATION, CONTACT THE NATIONAL ARCHIVES AT COLLEGE PARK, MARYLAND. (202) 837-1234

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15588

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15591

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN lb <u>5 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Hosp.</u>		d. STREET ADDRESS <u>Schoor St</u>	
3. NAME OF DECEASED (Type or print) First <u>Benson</u> Middle <u>C</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>11</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/31/96</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Lexington, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Corea Walling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>287-07-1622</u>	
17. INFORMANT <u>Beulah Campbell</u>		Address <u>Hosp</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>9040</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of spleen</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11/18/66</u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cambridge Md.</u> (County) <u>Carroll</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		22. DATE SIGNED <u>11/27/66</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>	23b. DATE THEREOF <u>Nov 29, 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City or Town) <u>Easton Md</u> (County) <u>Carroll</u> (State) <u>Md</u>
24. FUNERAL DIRECTOR <u>Robert Clark</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 28 1966</u>			

12524

12524



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15589

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15592

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b> c. LENGTH OF STAY IN b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Belle Haven Nursing Home</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b> d. STREET ADDRESS <b>110 Buena Vista Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Whitney</b> Last <b>Lord</b>			4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1966</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>November 23, 1883</b>		9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Grocery Store Owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Utica, New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Edward Lord</b>		
14. MOTHER'S MAIDEN NAME <b>Whitney</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>217-16-9576</b>			17. INFORMANT <b>Nellie S. Lord, Federalsburg, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinomatosis</b> <b>1810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the bladder</b> DUE TO (c) <b>Old healed TBC Pulmonary Emphysema</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6-8 mos</b> <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old healed TBC Pulmonary Emphysema</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>11/3/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/3/66</b> , 19 <b>66</b> , and that death occurred at <b>6:45 PM</b> on <b>11/6</b> , 19 <b>66</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Harold B. Plummer MD.</b>		22b. DATE SIGNED <b>NOV 10 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Harold B. Plummer MD.</b>	
22d. ADDRESS <b>Preston Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>Nov. 8, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Federalsburg, Maryland</b>	
24. FUNERAL DIRECTOR <b>J. J. Hampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

15593

15593

Correspondent

Florida

3 days

February 1963

110 North Vista Avenue

Belle Haven Nursing Home

Frank

Whitney

Love

November 8, 1962

Date

Retired Grocery Store Owner

Holmes, New York

Edward Land

01-16-9216 Nellie E. Love, Federalburg, Maryland

No

01-16-9216

1962

Nov. 8, 1960 with Grant Cameron

U.S. Attorney and Hon. Federalburg, Maryland

NOV 11 1962

Federalburg, Maryland

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME/5  
6M 1/66

15590

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15593

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glasgow Nursing Home</b>			d. STREET ADDRESS <b>Glenburn Avenue</b>		
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>GEOGHEGAN</b> Last <b>McALLISTER</b>			4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 66</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1877</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Philemore Geoghegan</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Maguire</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>Unk</b>			17. INFORMANT Address <b>Mrs. Lucille Bryan, Washington, D. C.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Fracture neck l. femur</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>22 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of bed in nursing home.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7:45 PM 10/27/66</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Glasgow nursing, Cambridge, Dor. Md.</b>	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. <b>John Mace Jr. M.D.</b>		22. DATE SIGNED <b>11/20/66</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 20 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>		
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 29 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

Film G383 - 11/29/66 - mnb - originally reported on regular  
death certificate and should have been on M.E. certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15591 CERTIFICATE OF DEATH 15594									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leroy</b>			First Middle Last		4. DATE OF DEATH <b>November 3 19 66</b>		Month Day Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Unknown</b> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>About 1895</b>		9. AGE (In years last birthday) <b>About 71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Factory &amp; Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Unknown</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Cambridge-Maryland Hospital Records</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Congestive heart failure</b> DUE TO (b) <b>Chronic uremia</b> DUE TO (c) <b>Arteriolel nephrosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>October 29, 1966</b> , to <b>November 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>November 19, 1966</b> , and that death occurred at <b>8:30 p.m.</b> , from the causes and on the date stated above.								22b. DATE SIGNED	
22a. SIGNATURE <b>Carlos F. Barros</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>CARLOS F. BARROSO MD</b>				22d. ADDRESS <b>ES State Hosp Cambridge Dorchester Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rhodesdale Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Near Rhodesdale, Maryland</b>		
24. FUNERAL DIRECTOR <b>P. Frampton and Son, Federalsburg, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 18 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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15594

Donor's Name

Donor's Name

Donor's Name

Donor's Name

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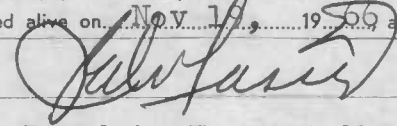
Donor's Name

Donor's Name



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
15592					15595					
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN lb <b>4 Days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>East New Market</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Lanette</b>		Middle		Last <b>Peterson</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 66</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 8, 1966</b>		9. AGE (In years last birthday) yrs. <b>1</b> Months <b>7</b> Days <b>19</b> Hours <b>66</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Orlan Henry</b>					14. MOTHER'S MAIDEN NAME <b>Ann Peterson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Orlan Henry, East New Market, Maryland</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Otitis Media</b> <b>3912</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 15, 1966</b> to <b>Nov 19, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 19, 1966</b> , and that death occurred at <b>11-19-66</b> M, from the causes and on the date stated above.										
22a. SIGNATURE  M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-19-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>					22d. ADDRESS <b>727 Pine Street., Cambridge, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Nov. 22, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Thompsons town Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Near East New Market, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE  <b>J. J. Frampton and Son</b>					ADDRESS <b>Federalburg, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 28 1966</b>		25b. REGISTRAR'S SIGNATURE 	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15593

15596

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Minutes</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		d. STREET ADDRESS <b>None</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD #3, near Lloyds, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ORVILLE</b> Last <b>PRITCHETT, Jr</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1948</b>
9. AGE (In years last birthday) yrs. <b>18</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Orville Pritchett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Keene</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mr. J. Orville Pritchett, Golden Hill, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra cranial injury</b> <b>519.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple fractures skull</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was driver of car which crashed.</b>	
20c. TIME OF INJURY Month, Day, Year Hour, a.m., p.m. <b>12 Midnight 11/27/66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway 343</b>		20f. (City or town) (County) (State) <b>Cambridge, Dor., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		22. DATE SIGNED <b>11/28/66</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 30 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15594

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15597

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		19.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Casson Neck Rd., RFD #3</b>		d. STREET ADDRESS <b>Casson Neck Road, RFD #3</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>AMANDA</b> First <b>HUBBARD</b> Middle <b>RHEA</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1878</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Hubbard</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Hubbard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs. Odie Wilcox, RFD #3, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>15 Mins.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
22. DATE SIGNED <b>11/21/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 22 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dail Family Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>James, Dor. Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		ADDRESS	
25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15595

15598

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>25 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> <b>09-1</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>805 Washington Street</b>				d. STREET ADDRESS <b>805 Washington Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Earl Rhodes</b>				4. DATE OF DEATH Month Day Year <b>Nov. 12 19 66</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 30, 1906</b>			
9. AGE (In years last birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Grocer</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Thomas Rhodes</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Isabella Hill</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT Address <b>Frederick Rhodes, M.D. New Orleans, La</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22. DATE SIGNED <b>11/15/66</b>	
ACTUAL SIGNATURE <b>Alfred R. Maryanov</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Alfred R. Maryanov, M.D. 610 Race St. Cambridge, Md.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial - Rem</b>		23b. DATE THEREOF <b>11/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Freindship</b>		23d. LOCATION (City or Town) (County) (State) <b>Spartansburg South Car</b>			
24. FUNERAL DIRECTOR <b>Frederick C. Delia</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			

MEDICAL CERTIFICATION

15552

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15596

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15599

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HURLOCK</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Academy</u>	
3. NAME OF DECEASED (Type or print) <u>MAY</u> First Middle Last <u>A. ROOK</u>		4. DATE OF DEATH <u>25 Nov</u> Month Day Year <u>19 66</u>	
5. SEX <u>+</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 May 1986</u>
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph B. Andrews</u>		14. MOTHER'S MAIDEN NAME <u>Mary Todd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>George H. Rook, Hurlock, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerotic heart disease</u> (c) <u>(?)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old left hemiparesis, Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THURSTON HARRISON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>EASTON</u>	
22. DATE SIGNED <u>1 Dec 66</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/28/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City or Town) (County) (State) <u>East New Market, Md</u>	
24. FUNERAL DIRECTOR <u>Beth S. Kellough, East New Market</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>DEC 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15597

## CERTIFICATE OF DEATH

17111

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE (RURAL)</b>			c. LENGTH OF STAY IN 1b <b>5 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRESTON, MARYLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Box 252 B</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>MAE</b> Last <b>SCHREIBER</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>29</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>05-11-94</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CANADA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>(XXXXXXXX) LAFEX</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNKNOWN No</b>			
16. SOCIAL SECURITY NO. <b>218-16-1311</b>				17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic debilitation</b> DUE TO (c) <b>—</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>26 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NA</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that <b>he</b> (this hospital) attended the deceased from <b>10-6-</b> , 19 <b>61</b> , to <b>11-29</b> , 19 <b>66</b> , that <b>he</b> (we) last saw the deceased alive on <b>11-29-1966</b> , and that death occurred at <b>3:30 P.M.</b> , from causes on and on the date stated above.	
22a. SIGNATURE <b>John Blair Webster</b>				22b. DATE SIGNED <b>29 Nov 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN BLAIR WEBSTER M.D.</b>	
22d. ADDRESS <b>EASTERN SHORE STATE HOSPITAL</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>Dec. 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		23d. LOCATION (City or Town) <b>Federalburg, Maryland</b>		23e. LOCATION (County) (State)	
24. FUNERAL DIRECTOR <b>J. J. Hampton &amp; Son Federalburg, Md</b>				25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

35537

## CERTIFICATE OF DEATH

1911

BIRTH DATE

BIRTH PLACE

A-THIRD RURAL

3 YEARS

BOSTON, MASSACHUSETTS

A-THIRD RURAL

BIRTH DATE

BIRTH PLACE

BIRTH DATE

BIRTH DATE

BIRTH DATE

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BIRTH DATE



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

156111

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (RURAL)</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 43 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>309 Pryor Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>C. Aker</u> Last <u>Shaffer</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-09-81</u>
9. AGE (In years lost birthday) yrs. <u>85</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Aker</u>		14. MOTHER'S MAIDEN NAME <u>Leah Still</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Records of Eastern Shore State Hospital</u>	
17. INFORMANT <u>Records of Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>904.7</u> DUE TO <u>TERMINAL PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>FRacture Neck R. Femur</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>4 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in hospital</u>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>8/8/1966</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) (County) (State) <u>Cambridge, Wicomico, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		22. DATE SIGNED <u>11/29/66</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE, THEREOF <u>12/1/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bedford Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Bedford Pa.</u>
24. FUNERAL DIRECTOR <u>MAUK &amp; YATES by Kenny Thorne</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 1966</u>	
ADDRESS <u>ALTOONA PA.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

15000

15000

15000



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15601

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>Rt. 1 Union Church Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Lester</b> Last <b>Shockley</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/17</b>
9. AGE (In years lost birthday) yrs. <b>49</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bread route</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Shockley</b>		14. MOTHER'S MAIDEN NAME <b>Ella Phillips</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Thomas F. Wallace, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide poisoning</b> <b>8915</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was found dead behind wheel of truck.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3</b> p.m. <b>11/14/66</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>US # 50 Highway</b>	20f. (City or town) (County) (State) <b>Nr. Linkwood, Dor. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		22. DATE SIGNED <b>11/18/66</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Md.</b>
24. FUNERAL DIRECTOR <b>Thomas F. Wallace</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 22 1966</b>	
ADDRESS <b>Salisbury, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10001

10001

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15600

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15602

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DQA Cambridge Maryland Hospital</b>		d. STREET ADDRESS <b>311 Glenburn Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>VIRGINIA</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May. Dec. 28, 1897</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Hubbard</b>		14. MOTHER'S MAIDEN NAME <b>Anna Vano</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs Agnes Jackson, Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> 5703 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Volvulus ileum</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		22. DATE SIGNED <b>11/14/66</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 16 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lawncroft Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>WILKINSON, DELAWARE</b>
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>Nov 16 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MD. STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15601

CERTIFICATE OF DEATH

15604

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLINGTON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS <b>14</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY REBECCA SPEAR</b>				4. DATE OF DEATH Month Day Year <b>NOV. 14 1966</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/84</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRAC. NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>RICHARD COMEGYS</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN <del>XXXXX</del> F. Foster</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 493x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General debility</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-23-66</b> , 19 <b>66</b> , to <b>November 14, 1966</b> that (I) (we) last saw the deceased alive on <b>November 14, 1966</b> , and that death occurred at <b>3:10</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Carlo F. Barros</b>				22b. DATE SIGNED <b>11-25-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Carlos F Barros MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Nov. 28, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Millington Cemetery</b>	
23d. LOCATION (City or Town) <b>Millington,</b>				23e. (County) <b>Kent</b>		23f. (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Elmer E. Brown</b>				24a. ADDRESS <b>Millington Md</b>		24b. REC'D BY REGISTRAR DATE <b>NOV 29 1966</b>	
24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				24d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Page 155

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15602

15605

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b> c. LENGTH OF STAY IN b <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bobtown</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b> d. STREET ADDRESS <b>Bobtown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>India</b> Middle <b>Mae</b> Last <b>Stanley</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>6</b> Year <b>1966</b>															
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 23, 1892</b>		<b>9. AGE</b> (In years last birthday) <b>74</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Eugene Augustus Holliday</b>								<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Mae McGlotten</b>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>219-07-6184</b>		<b>17. INFORMANT</b> <b>Phillip L. Holliday, Hurlock, Md., RFD</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Chronic myocarditis</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Hypertension</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1964</b> , 19____, to <b>11-6-66</b> 19____, that (I) (we) last saw the deceased alive on <b>11-6-66</b> 19____, and that death occurred at <b>5</b> A.M. from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <b>Frank M. Anderson</b> M.D.								<b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Frank M. Anderson M.D.</b>		<b>22d. ADDRESS</b> <b>Federalsburg, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov. 9, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Federal Hill Cemetery</b>				<b>23d. LOCATION (City, town or county)</b> (State) <b>Federalsburg, Maryland</b>									
<b>24. FUNERAL DIRECTOR</b> <b>Frank M. Anderson Jr.</b> <b>Frampton Funeral Home, Federalsburg, Maryland</b>								<b>25a. REC'D BY REGISTRAR</b> <b>NOV 18 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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1

15603

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15606

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> 05-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Sudler</u> Last <u>Sudler</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>24</u> Year <u>1966</u>	
5. SEX <u>♀</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>83</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alex. Gaud</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>E.S.S. H. Records</u>		Address <u>Cambridge</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriolan nephrosclerosis</u> DUE TO (c) <u>3 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> , 19 <u>66</u> to <u>11-24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-24</u> , 19 <u>66</u> , and that death occurred at <u>10:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Carlos F. Barruso</u>		22b. DATE SIGNED <u>11-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F BARRUSO</u>		22d. ADDRESS <u>ESS Hosp. Cambridge Dorchester Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-28-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	23d. LOCATION (City or Town) (County) (State) <u>Goldsboro, Md.</u>
24. FUNERAL DIRECTOR <u>R. E. Baulais Greensboro Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15600

CERTIFICATE OF DEATH

15600

MAY 20, 1966



IN WITNESS WHEREOF

15600

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15600

*Handwritten signature*



## 15604

# CERTIFICATE OF DEATH

15607

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD</b>		b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>3.5 yrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE, MD.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <b>907 Phillips St. Cambridge</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest</b>		First <b>Sutton</b>		Middle <b>Sutton</b>	
4. DATE OF DEATH <b>11/25/66</b>		Month <b>11</b>		Day <b>25</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb 2, 1913</b>		9. AGE (In years last birthday) <b>53</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>25</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>Yes</b>		13. FATHER'S NAME <b>Charles C. Sutton</b>	
14. MOTHER'S MAIDEN NAME <b>Rachel Bons</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1944-1946</b>	
17. INFORMANT <b>Viola Sutton, 907 Phillips, Camb.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Severe Hypertensive C.V.D.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cong. Abscess, Uremia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cambridge</b>		(County) <b>Dorchester</b>	
(State) <b>MD</b>		21. I certify that (I) (this hospital) attended the deceased from <b>11-5-66</b> to <b>11-25-66</b> , that (I) (we) last saw the deceased alive on <b>11-25-66</b> , and that death occurred at <b>10:15</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>T. Edwin Fasset</b>	
22b. DATE SIGNED <b>11-25-66</b>		22c. PHYSICIAN'S NAME (Type) <b>T. Edwin Fasset</b>		22d. ADDRESS <b>Cambridge Md.</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>11/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beckwith Neck Cambridge</b>	
23d. LOCATION (City, town or county) <b>Cambridge</b>		(State) <b>MD</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Booker M. West</b>	
24a. ADDRESS <b>Cambridge</b>		24b. REC'D BY REGISTRAR <b>DEC 2 1966</b>		24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

VR A15 (4)  
20M 5.63

15002

15002

Handwritten notes and signatures, including "General", "P. P. P.", and "P. P. P.", along with various dates and initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15605					15608				
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>50 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			d. STREET ADDRESS <b>417 Bayly Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>417 Bayly Avenue</b>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>GUY</b> <b>R.</b> <b>TALL</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>8,</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 23, 1890</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Thomas Tall</b>					14. MOTHER'S MAIDEN NAME <b>Lonie Pritchett</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT Address <b>Mr. Webster Tall, Cambridge, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arterio-sclerotic cardio vascular disease</b> DUE TO (c) <b>Generalized arterio-sclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 - 4 days</b> <b>4 - 5 year</b> <b>4 - 5 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>(the husband)</del> attended the deceased from <b>January, 19 62</b> to <b>November 8, 19 66</b> , that (I) <del>(we)</del> saw the deceased alive on <b>November 7, 19 66</b> , and that death occurred at <b>2:12 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Eldridge H. Wolff</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-10-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>				22d. ADDRESS <b>615 Locust Street, Cambridge, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 10 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service, Cambridge, Maryland</b>				ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

20321

20821

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15606

CERTIFICATE OF DEATH

15609

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN TB <u>6 yrs 8 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Eden</u>		19-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>RFD # 2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Taylor</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>Fm</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-87</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Emma Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Eastern Shore State Hospital - Med. Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>General debility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 21, 1966</u> , to <u>November 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>November 5, 1966</u> , and that death occurred at <u>3:20 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Carlos F Barroso</u>		22b. DATE SIGNED <u>11-5-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO MD</u>		22d. ADDRESS <u>ESS Hosp - Cambridge Dorchester Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Allen Md</u>
24. FUNERAL DIRECTOR <u>Lewis R. Wilson</u>		25a. REC'D BY REGISTRAR <u>J. P. Jones</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 7 1966</u>	



20221

1981



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

FOR STATE  
HEALTH DEPT.

15607

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15610

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Daroline</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookview</b>			c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>				d. STREET ADDRESS <b>111 Central Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>L.</b> Last <b>Terrell</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>6</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 1, 1942</b>		
9. AGE (In years last birthday) yrs. <b>24</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bakery</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Augusta Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Terrell</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Meeks</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>230-52-3919</b>		17. INFORMANT Address <b>Hospital Records, Cambridge, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending autopsy Carbon monoxide poisoning</b> 872.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Carbon monoxide poisoning</b>					
20c. TIME OF INJURY Month, Day, Year <b>? Hour a.m. 11/4 1966</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Brookview Dorchester Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Lawrence Maryanov</b>			M.D.			22. DATE SIGNED <b>Nov 6 1966</b>		
EXAMINER'S NAME (Type) <b>Lawrence Maryanov</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <b>Cambridge Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 10 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Charlottesville, Virginia</b>		
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>		

MEDICAL CERTIFICATION

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15608

## CERTIFICATE OF DEATH

15611

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE (RURAL)</b>			c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PRINCESS ANNE,</b>			19-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS <b>ROUTE #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNARD J. THOMAS</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 15 1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>08-04-93</b>		9. AGE (In years lost birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>SOMERSET Co.-Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>NELLIE DASHIELL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma of the lung</b> <b>165X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — DUE TO (b) — (c) —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>July 6</b> , 19 <b>66</b> to <b>Nov 15</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>Nov 15</b> , 19 <b>66</b> , and that death occurred at <b>5:20</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>John Blair Webster</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>15 Nov 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John James Blair Webster M.D.</b>				22d. ADDRESS <b>EASTERN SHORE STATE HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 18, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		23d. LOCATION (City or Town) (County) (State) <b>Mt. Vernon Somerset, Md</b>	
24. FUNERAL DIRECTOR <b>James J. Hirman, Princess Anne</b>				25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15011

CERTIFICATE OF DEATH

15008

DECEASED

RURAL

WANTS

PRINCIPAL NAME

EASTERN SHORE STATE HOSPITAL

ROUTE 1

BIRMINGHAM

THOMAS

NOVEMBER 19

WHITE

10-4-03

13

DATE OF

DECEASED

OFFICIAL TITLE

MEDICAL ASSISTANT

RECORDS OF THE EASTERN SHORE STATE HOSPITAL

UNKNOWN

1	2	3	4	5	6	7	8	9	10	11	12

EASTERN SHORE STATE HOSPITAL

A. C. LAIR, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15609 CERTIFICATE OF DEATH 15612

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Md. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>407 Maryland Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Howard Twilley</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Jan '06</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Wm. J. Twilley</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Wright</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 2</b>	
17. INFORMANT <b>Mrs. W. Howard Twilley</b>		Address <b>Cambridge Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED METASTATIC ADENOCARCINOMA</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA OF COLON</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1-2 MONTHS</b> <b>6-7 MONTHS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>JULY</b> , 19 <b>66</b> , to <b>NOV 28</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>NOV 28</b> 19 <b>66</b> , and that death occurred at <b>9:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James F. McArthur</b>		22b. DATE SIGNED <b>11-30-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES FRANKLIN MCARTER, M.D.</b>		22d. ADDRESS <b>704 LOCUST STREET</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1 Dec. '66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>E. New Market Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>E. New Market Md.</b>	
24. FUNERAL DIRECTOR <b>Robert R. Thomas Jr.</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>James F. McArthur</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)  
20M 1/66

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
15613									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> 09.1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital, Inc.</b>					d. STREET ADDRESS <b>400 Pine Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lillian Coleman Walden</b>			First Middle Last		4. DATE OF DEATH <b>Nov. 30 1966</b>		Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 2, 1896</b>		9. AGE (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Esau Pratt Coleman</b>					14. MOTHER'S MAIDEN NAME <b>Eliza Jane Sampson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>176-20-2357</b>		17. INFORMANT <b>Emerson Walden, M.D. Baltimore, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>11-20</b> , 19 <b>66</b> , to <b>11-30</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-30</b> , 19 <b>66</b> , and that death occurred at <b>11-30</b> , 19 <b>66</b> , M, from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-5-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>					22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/3/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Waugh</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>			
24. FUNERAL DIRECTOR <b>[Signature]</b>					ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1966</b>		
					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				



15611

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b> c. LENGTH OF STAY IN TB <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>										<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b> d. STREET ADDRESS <b>None RFD #3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>JANE H. WALTER</b>										<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>2,</b> Year <b>1966</b>									
<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Nov. 1894</b> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>9. AGE (In years last birthday)</b> <b>72 yrs.</b> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.										<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unknown</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Kennett Sq., Penna.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>									
<b>13. FATHER'S NAME</b> <b>Alban W. Walter</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Sara Scudder</b>										<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b> <b>17. INFORMANT</b> <b>Mr. Joseph Walter, Cambridge, Maryland</b> Address									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Coronary atherosclerosis</b> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 days</b>									
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)										<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>										<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>10-26, 1966</b> <b>to</b> <b>11-2, 1966</b> <b>that (I) (we) last saw the deceased alive on</b> <b>11-1, 1966</b> <b>and that death occurred at</b> <b>6:15 AM</b> <b>from the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <b>Richard G. Bilodeau</b> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <b>11-2-66</b>										<b>22c. PHYSICIAN'S NAME (Type)</b> <b>RICHARD G. BILODEAU</b> <b>22d. ADDRESS</b> <b>CITY OFFICE BLDG., CAMBRIDGE, MD.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Nov. 5, 1966</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Union Hill Cemetery</b> <b>23d. LOCATION (City, town or county)</b> <b>Kennett Square, Penna.</b> (State)																			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>LeCompte Funeral Service, Cambridge, Maryland</b> <b>ADDRESS</b>										<b>25a. REC'D BY REGISTRAR</b> <b>DATE NOV 4 1966</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>									

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15612

## CERTIFICATE OF DEATH

15615

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> <span style="float: right;">2 Days</span> c. LENGTH OF STAY IN b. <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Dorchester</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b> d. STREET ADDRESS <b>R.F.D. # 1-Box40</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary</b>		First <b>Mary</b> Middle <b>L. E.</b> Last <b>Waters</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>19</b> Year <b>19 66</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 9, 1887</b>	<b>9. AGE</b> (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Factory work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Wrights Cannery</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Dorchester County, Md.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>Alexander Thompson</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Louise Teagle</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>161-14-0332</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>William H. Waters, Jr., Hurlock, Md. R.D.#1-Box 40</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	(County)	(State)		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Jan 1, 1965</b> <b>to</b> <b>Nov 19, 1966</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Nov 19, 1966</b> <b>and that death occurred at</b> <b>.....M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> 		<b>22b. DATE</b> <b>11-19-66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. Edwin Fassett, M.D.</b>			
<b>22d. ADDRESS</b> <b>727 Pine St., Cambridge, Md.</b>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Nov. 23, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Petersburg Cemetery</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Near Hurlock, Maryland</b>		(State)					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> 		<b>ADDRESS</b> <b>J. J. Brampton and Son, Federalsburg, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>NOV 28 1966</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> 							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15613

CERTIFICATE OF DEATH

15616

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN TB <u>5 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		d. STREET ADDRESS <u>321 East Locust St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>MAE</u> Last <u>White</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>19 66</u>	
5. SEX <u>Fm.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-91</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SUSSEX COUNTY, DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BEN MARTIN Ellingsworth</u>		14. MOTHER'S MAIDEN NAME <u>Martha TOOMEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-8066D</u>	
17. INFORMANT <u>Mrs. Mae Hill (Daughter)</u>		Address <u>Eastern Shore State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive heart failure</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>9 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. Rieckert</u>		22b. DATE SIGNED <u>11-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. Rieckert</u>		22d. ADDRESS <u>E-New Market</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 16, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury Maryland</u>	
24. FUNERAL DIRECTOR <u>Hollaway Co. Salisbury Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



12612

BUREAU OF DEATH

12612

1. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

2. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

3. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

4. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

5. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

6. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

7. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

8. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

9. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.

10. I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Bureau of Death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15614

## CERTIFICATE OF DEATH

15617

1. PLACE OF DEATH e. COUNTY <b>Dorchester</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>				d. STREET ADDRESS <b>512 Goldsborough Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>D.</b> Last <b>WILLEY</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1907</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b>	IF UNDER 24 HRS. Hours <b>59</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Highway Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. State Highway</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard Willey</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Robbins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mrs. Raymond D. Willey, Cambridge, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 Min</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/1/60</b> , 19 <b>66</b> , to <b>11/3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/3/66</b> , 19 <b>66</b> , and that death occurred at <b>7 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John Mace Jr.</b>				22b. DATE SIGNED <b>NOV 3 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>John Mace Jr.</b>				22d. ADDRESS <b>Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15615

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15618

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND ✓		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN 1b <u>4 mo. 22 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		05-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>103 South 7th St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annabell</u> Middle <u>Williams</u> Last <u>William</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/1880</u>
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>21</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Lord</u>		14. MOTHER'S MAIDEN NAME <u>Russum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Medical Records Eastern Shore State Hospital</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> 9037 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>FRACTURE NECK L. FEMUR</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>4 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>FELL IN CORRIDOR OF HOSPITAL</u>	
20c. TIME OF INJURY Month, Day, Year <u>6</u> Hour a.m. <u>10-20</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOSPITAL</u>		20f. (City or town) (County) (State) <u>CAMBRIDGE MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		22. DATE SIGNED <u>11/21/66</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE THEREOF <u>Nov 23, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CONCORD</u>		23d. LOCATION (City or Town) (County) (State) <u>CONCORD, CAROLINE, MD.</u>	
24. FUNERAL DIRECTOR <u>J. Virgil Mooreson Denton Md</u>		ADDRESS <u>—</u>	
25a. REC'D BY REGISTRAR <u>NOV 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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WILLIAM H. HARRIS, JR.

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WILLIAM H. HARRIS, JR.

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WILLIAM H. HARRIS, JR.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
15616					15619				
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Md. Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>Arcade Apts. Race St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Elizabeth Charlotte Wright</b>			4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1966</b>						
5. SEX <b>Fe</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 1, 1885</b>		9. AGE (In years last birthday) <b>81</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Doenges Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Dorothy Schott</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>222-12-9146</b>		17. INFORMANT <b>Mrs. Louise Wright</b>		Address <b>Belvedere Ave. Cambridge Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Broncho Pneumonia</b> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Uremia</b> DUE TO (c) <b>Cerebral hemorrhage, left</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Arteriosclerosis generalized</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>November 8, 1966</b> to <b>November 10, 1966</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>November 10, 1966</b> , and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Eldridge H. Wolff</b>					22b. DATE SIGNED <b>11-12-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>					22d. ADDRESS <b>615 Locust Street, Cambridge, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery Cambridge, Maryland</b>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <b>Herbert H. Brown Jr.</b>					ADDRESS <b>Cambridge Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15617 CERTIFICATE OF DEATH 15620

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland</u>		d. STREET ADDRESS <u>R.F.D. Box 9</u>	
3. NAME OF DECEASED (Type or print) First <u>Lavenia</u> Middle <u>J.</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James H. Stewart</u>	
14. MOTHER'S MAIDEN NAME <u>MARY E. BALL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>219-05-085</u>	
16. SOCIAL SECURITY NO. <u>219-05-085</u>		17. INFORMANT <u>Helen Pinkett</u> Address <u>Vienna, R.F.D. Box 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1966</u> to <u>Nov. 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 16, 1966</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11.16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>		22d. ADDRESS <u>727 Pine St., Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-20-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Vienna Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Vienna, Maryland</u>	
24. FUNERAL DIRECTOR <u>Loretta B. Jolley - Jersey Rd. Rt #2 Sals</u>		25a. REC'D BY REGISTRAR <u>NOV 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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